

12660 CERTIFICATE OF DEATH

Reg. Dist. No. 12618

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Connecticut</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>5 hrs 40 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARROLL</u> Middle <u>ALOKONIS</u> <u>Infant</u> <u>Alokonis</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 5, 1957</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Felix Alokoni</u>		14. MOTHER'S MAIDEN NAME <u>Carol Ann Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father, Old Dorsey Rd, Harmans, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>Prematurity</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 hrs 40 min</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 Dec</u> , 19 <u>57</u> , to <u>5 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5 Dec 57</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Charles F. Gill</u> M.D. <u>USAH, Ft. G. G. Meade, Maryland</u>		DATE SIGNED <u>5 Dec 57</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES F. GILL, Capt, MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel National</u>	22d. LOCATION (City, town or county) (State) <u>2800 Federal Ge, Bethel</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Downs</u> ADDRESS <u>6306 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>Walter H. Downs, Jr.</u> DATE <u>6 Dec 57</u>	24b. REGISTRAR'S SIGNATURE <u>Walter H. Downs, Jr.</u> DATE <u>6 Dec 57</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12661

Items 4, 8, See: Birth Cert. et

CERTIFICATE OF DEATH

13801

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Fort George G. Meade</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fort George G. Meade</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade</u>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort G. G. Meade, Md.</u>		e. STREET ADDRESS <u>111 Goodman St.</u>	
3. NAME OF DECEASED (Type or print) <u>INF MALE</u> Middle <u>ANDERSON</u>		4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1957</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME <u>Anderson, Albert</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Wade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT FATHER. 1510D Meade Dale, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>Prematurity</u> PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>31 Dec 57</u> , 19, to <u>31 Dec 57</u> , 19, that I last saw the deceased alive on <u>31 Dec 57</u> , 19, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank L. Gruskay</u>		DATE SIGNED <u>USA Hosp Ft 66m. Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK L. GRUSKAY</u>		M.D.	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Woberton Funeral Home, Inc</u>		24a. REC'D BY REGISTRAR DATE <u>31 Dec 57</u>	
ADDRESS <u>Belair Rd, Baltimore-6, Md</u>		24b. REGISTRAR'S SIGNATURE <u>WILBUR H DOWNS JR CAPT</u>	

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12619

Reg. Dist. No.

12623

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jonestown, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Melvin</u> First <u>Barley</u> Middle <u>Barley</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grave Digger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hilcrest Ceme.</u>	
11. BIRTHPLACE (State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Ann Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>614-05-1896</u>	
17. INFORMANT <u>Agnes Bailey Jones, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> 494.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stopes Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>12/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
VITAL RECORDS EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

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12624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>				d. STREET ADDRESS <i>1 R. 7 D. 2 Annapolis</i>			
3. NAME OF DECEASED (Type or print) First <i>Maurice E.</i> Middle <i>Baldwin</i> Last <i>Baldwin</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>31</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-16-1889</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer (truck)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer (truck)</i>		11. BIRTHPLACE (State or foreign country) <i>AA Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William P. Baldwin</i>				14. MOTHER'S MAIDEN NAME <i>Amanda Statlings</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bertha W. Baldwin</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion P (DOA)</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-2-58</i> , 19 <i>58</i> , to <i>4-6-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4-6-</i> , 19 <i>57</i> , and that death occurred at <i>?</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. <i>63 College Ave</i>				DATE SIGNED <i>1-3-58</i>			
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>				<i>Annapolis, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1-3-58</i>		<i>Cosbury Cemetery</i>		<i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>				ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>1958</i>	
						24b. REGISTRAR'S SIGNATURE <i>Mr. J. French</i>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

Form No. 100-101

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

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PLACE OF DEPARTURE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>aa</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Epping Forest</i> d. STREET ADDRESS <i>Vineyard Trail</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Velma</i> Middle <i>Ann</i> Last <i>Barry</i>		4. DATE OF DEATH Month <i>12</i> - Day <i>13</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 24 - 1868</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>13</i>	11. IF UNDER 24 HRS. Hours <i>13</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Potsdam N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Mc Cormick</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Edwin M. Barry</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4343</i> DUE TO <i>Cardiac Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>[Signature]</i>		DATE SIGNED <i>12/13/57</i>	
EXAMINER'S NAME (Type) <i>E. F. W. H. A. S. T.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>12-15-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bay Side Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Potsdam N.Y.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Kelly In Sons</i>		ADDRESS <i>Annapolis Md.</i>	
24a. REC'D BY REGISTRAR <i>[Signature]</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
DATE <i>12/16/57</i>			

MEDICAL CERTIFICATION

2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

DEC 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12663 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maine b. COUNTY Cumberland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b 6 Months			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portland				d. STREET ADDRESS 81 Ocean Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NAKA Middle K ATO Last BENNETT				4. DATE OF DEATH Month December Day 16 Year 19 57			
5. SEX Female		6. COLOR OR RACE Mong		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 April 1923	
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Japan	
12. CITIZEN OF WHAT COUNTRY? Japan							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband, Sgt Bennett, 1709 D Forrest Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of stomach with peritoneal dissemination 151X DUE TO Gastroenterostomy, ruptured Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Purulent peritonitis DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4 Dec , 19 57 , to 16 Dec , 19 57 , that I last saw the deceased alive on 16 Dec , 19 57 , and that death occurred at 0445 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAH, Ft G. G. Meade, Md. 16 Dec 57							
ACTUAL SIGNATURE KENWYN G. NELSON, Maj, MC				PHYSICIAN'S NAME (Type) KENWYN G. NELSON, Maj, MC			
22a. DATE OF REMOVAL (Specify) Removal		22b. DATE THEREOF 12-17-1957		22c. NAME OF CEMETERY OR CREMATORY Frank Hobbs Funeral Home		22d. LOCATION (City, town or county) (State) South Portland, Maine	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Woberton Funeral Home, Inc				24a. REC'D BY REGISTRAR DATE 16 Dec 57		24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC	

6306-Belair Rd - Baltimore - 6, Md

PLANNED

DEC 1951

1951

12664 CERTIFICATE OF DEATH

12623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>17A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWENSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 OWENSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM WHITTINGHAM Billard</u>		4. DATE OF DEATH Month Day Year <u>DEC 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/80</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	
11. BIRTHPLACE (State or foreign country) <u>Laurel Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jules Frederic Billard</u>		14. MOTHER'S MAIDEN NAME <u>Lillian K. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212 01164A</u>	
17. INFORMANT <u>Major Jules F. Millard Fort Knox, Ky.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVR Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>8 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 Dec</u> , 19 <u>57</u> , and that death occurred at <u>1:15 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Lamer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Upper Marlboro Md 12 Dec 57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>	22d. LOCATION (City, town, or county) (State) <u>OWENSVILLE Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Baltimore Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 23 57</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. Lamer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR THE U. S.

NO. 1057

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1-3-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2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FORWARD V. S.

EC 18 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12626

CERTIFICATE OF DEATH

12625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Q. Q.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hosp</u>		e. STREET ADDRESS <u>50 Murray Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Jena</u> Middle <u>E.</u> Last <u>Brewer</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Fayetteville N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Weldon Evans</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Master S. Brewer</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>34 HOURS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC</u> , 1956, to <u>11 DEC</u> , 1957, that I last saw the deceased alive on <u>11 DEC</u> , 1957, and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward A. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ceme</u> DATE SIGNED <u>12/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Danville Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>12/12/57</u> DATE	
		24b. REGISTRAR'S SIGNATURE	

RECEIVED

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12665 CERTIFICATE OF DEATH

12626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Truck House Rd.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			
c. LENGTH OF STAY IN 1b <u>36 yrs</u>				d. STREET ADDRESS <u>Truck House Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Truck House Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Bernard</u> Last <u>Broedner</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Carl Bernard Broedner</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>wife</u>		Address <u>Severna Park Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Constrictive Pericarditis</u> (c) <u>Generalized Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>to Dec 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 Dec</u> , 19 <u>57</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>				DATE SIGNED <u>12-29-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCarthy Funeral Homes</u>				ADDRESS <u>130 E. Fort me.</u>		24. REC'D BY REGISTRAR <u>DATE 12-31-57</u>	
25. REGISTRAR'S SIGNATURE <u>L. J. Healy</u>							

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DEC 1947

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12666 CERTIFICATE OF DEATH

12628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 3 yr, 10 mo & 8 da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 904 E. North Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daisy Middle Brown Last Brown		4. DATE OF DEATH Month 12 Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter Dashields		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Hypostatic Pneumonia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) Left Hemiplegia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 9 , 19 54 , to December 17 , 19 57 , that I last saw the deceased alive on December 17 , 19 57 , and that death occurred at 11:45 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 12/18/57			
ACTUAL SIGNATURE Ludwig Benedict		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Brookland; Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Roy O. Wilson		ADDRESS	
24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE A. M. Jones	

MEDICAL CERTIFICATION

BUNNAN V. S.

DEC 1957

RECEIVED

12627 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Exoch</u> First <u>Exoch</u> Middle <u>Comp</u> Last <u>Comp</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1879</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Bd. Comm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Comp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, how long) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Allen Comp</u> Address <u>Capitol Hill</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-13</u> , 19 <u>57</u> , to <u>Dec. 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Smith H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Sutton, Md.</u> DATE SIGNED <u>12-16-57</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chapin Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Crownsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>12/18/57</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A

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1950

RECEIVED

DEC 30 1957

BUREAU V. S.

12629
CERTIFICATE OF DEATH

Reg. Dist. No.

12630

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship A.A. Co.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Beauce</u> Middle <u>Coates</u> Last <u>Coates</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1901</u>
9. AGE (In years last birthday) <u>26</u>		IF UNDER 1 YEAR: Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Isaac Rawlins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Leonard Coates</u>		Address <u>Friendship A.A. Co.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Cystic Tumor of Cerebellum</u> DUE TO <u>Type to be determined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Type to be determined</u> DUE TO (c) <u>Type to be determined</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 8, 1957</u> to <u>Nov 20, 1957</u> , that I last saw the deceased alive on <u>Nov 28, 1957</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-Clay Street, Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON M.D.</u>		DATE SIGNED <u>12/26/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt hope</u>	22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. E. Sewell</u>		ADDRESS <u>Prince Fred, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 12-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Wark</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 10 1944
BUREAU V. S.

12630 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12631

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS.			
c. LENGTH OF STAY IN 1b 15 YRS.				d. STREET ADDRESS 1500 WEST ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSP				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
GRACE		A. CRITZER		12		3 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/14/96	61 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME CHARLES C. REID				14. MOTHER'S MAIDEN NAME MARE ELIZABETH LOVELY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO.		17. INFORMANT Address LUTHER E CRITZER, ANNAPOLIS, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT CEREBRAL ARTERY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 PM DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERIPHERAL NEURITIS DUE TO DIETARY INSUFFICIENCY							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16 , 19 57 , to 12/3 , 19 57 , that I last saw the deceased alive on 12/3 , 19 57 , and that death occurred at 5:46 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 68 Franklin St DATE SIGNED Annnapolis, Md.							
ACTUAL SIGNATURE Richard N. Peeler		M.D. Richard N. Peeler					
PHYSICIAN'S NAME (Type) RICHARD N. PEELER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DEC 8 1957		24b. REGISTRAR'S SIGNATURE Tom French	

DEPT. OF JUSTICE

RECEIVED

RECEIVED

12631 CERTIFICATE OF DEATH

12632

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>23 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ PAROLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH ANNAPOLIS, MD.</u>				d. STREET ADDRESS <u>HOLMPORT FARM</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>CHARLES</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1885</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>O. GON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>ADLINE WARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>USNH ANNAPOLIS, MARYLAND</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> DUE TO Candilions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, Sigmoid Colon</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>5 December, 19 57</u> , to <u>6 December, 19 57</u> , that I last saw the deceased alive on <u>6 December, 19 57</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Busse, Jr.</u>		ADDRESS (Street, city or town, state) <u>M.D. U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>12-6-57</u>					
PHYSICIAN'S NAME (Type) <u>Robert J. BUSSE, Jr.</u>		Lieutenant, Medical Corps, U.S. Navy					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>ECY</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

DEC

1953 NOV 11

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12632

CERTIFICATE OF DEATH

Reg. Dist. No.

12633

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 4 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL.		e. STREET ADDRESS 110 ARCHWOOD AVE	
3. NAME OF DECEASED (Type or print) First ROENA Middle A. Last DAVIS		4. DATE OF DEATH Month 12 Day 25 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-76
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR: Months 12 Days 25 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME MOSES ATHERTON		14. MOTHER'S MAIDEN NAME GEORGIA DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS. H. G. WEAVER		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c)).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERIPHERAL VASCULAR COLLAPSE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMBOLUS DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 HRS 2 PM.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUGUST , 1957, to 12/25 , 1957, that I last saw the deceased alive on 12/25 , 1957, and that death occurred at 10:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard N. Peeler M.D.		ADDRESS (Street, city or town, state) 68 FRANKLIN ST. ANNAPOLIS, MD.	
PHYSICIAN'S NAME (Type) RICHARD N. PEELER		DATE SIGNED 12/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-28-57	22c. NAME OF CEMETERY OR CREMATORY HILLCREST	22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		ADDRESS Annapolis, Md	
24a. REC'D BY REGISTRAR 12/26/57		24b. REGISTRAR'S SIGNATURE —	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1977

RECEIVED

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The form copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film 223 12-23-57 ams

CERTIFICATE OF DEATH

12634

Reg. Dist. No. 21

12633

Item 2 Film 223 12-13-57 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Massachusetts Maryland		COUNTY Worcester Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis		LENGTH OF STAY (In this place) 1 year		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Medford Medford			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Academy				STREET ADDRESS Annapolis, Maryland 60 Woturn street			
3. NAME OF DECEASED (First) (Middle) (Last) Joseph Alfred DeMasi				4. DATE OF DEATH (Month) (Day) (Year) Dec. 7 19 57			
5. SEX Male	6. RACE OR COLOR White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH February 1 1938	9. AGE last birthday 19 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) New Haven, Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Joseph D. DeMasi				14. MOTHER'S MAIDEN NAME Gertrude Bond DeMasi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 015-30-0620		17. INFORMANT & ADDRESS U.S. Navy Records			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Strangulation				Unknown			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Dormitory		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Annapolis Anne Arundel Maryland			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) December 7 1957 0:40 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Investigation being 6666666666/ Inapparent suicide			
22. I hereby certify that I attended the deceased from 12-7 1957, to 12-7 1957, that I last saw the deceased alive on 12-7 1957, and that death occurred at 0:40a.m. from the causes and on the date stated above.							
SIGNATURE Maynard L. Sisler, LT, MC, USN				ADDRESS (Street, city, town, state) U.S. Naval Academy, Annapolis, Md		DATE SIGNED 12-7-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 12-8-57		NAME OF CEMETERY OR CREMATORY Medford, Massachusetts		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE DEC 11 1957		REGISTRAR'S SIGNATURE Wm. J. French		25. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	

RECEIVED

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's P.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian, P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence Dorsey</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1919</u>
9. AGE (In years last birthday) <u>38</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Prury Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Selman</u>		14. MOTHER'S MAIDEN NAME <u>Pruth Selman Prury Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Pruth Selman Prury Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephylacetic Shock</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Penicillin (over response)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-5-57</u> , 19 <u>57</u> , to <u>12-5-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-5-57</u> , 19 <u>57</u> , and that death occurred at <u>1:50</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. T. Allen</u>		ADDRESS (Street, city or town, state) <u>612 Cathedral St</u> DATE SIGNED <u>12-7-57</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		<u>anaphylactic and</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-9-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woods</u>	22d. LOCATION (City, town, or county) (State) <u>Prury Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Bessett</u> ADDRESS <u>108 W. 1st St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 9 57</u>	24b. REGISTRAR'S SIGNATURE <u>W. B. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 10 1901
BUREAU V. S.

12667 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale, Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale, Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>816 Dale Road</u>		d. STREET ADDRESS <u>816 Dale Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>Frederick</u> Last <u>Emge, Jr.</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1957</u>	
II. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hughes Hdw. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Emge</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Stemmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-08-2899</u>	
17. INFORMANT <u>W. Wilbur Emge, Jr.</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>with cardiac decompensation</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 15, 1951</u> , to <u>Dec. 11, 1957</u> , that I last saw the deceased alive on <u>Dec. 10, 1957</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Mountain Road Pasadena Md. Dec 18, 1957</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Langhorne</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>REC'D</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 1 1967

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12637

12668 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN	
CITY OR TOWN <u>GLENN BURNIE</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>2805 Evergreen Ave.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DAVID</u> (Middle) <u>L.</u> (Last) <u>ESPEY</u>				(Month) <u>Dec</u> (Day) <u>14</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 25 1888</u>	9. AGE last b'n' day <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Romeo Espey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Lyschun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <u>2805 Evergreen</u> <u>Miss Adelaide Stuckinger</u> # 4			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4x10 IMMEDIATE CAUSE (A) <u>CORDINARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS GENERAL</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> to <u>Dec 14 1957</u> , that I last saw the deceased alive on <u>Dec 11 1957</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph V. Alet</u>		ADDRESS (Street, city, town, state) <u>1023d A Blvd. N.E. Washington, D.C.</u>		DATE SIGNED <u>Dec 14-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>12/17/57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec 14 57</u>		<u>L. Y. Adley</u>		<u>Buch 5305</u>		<u>Harford</u>	

RECEIVED

1950

RECEIVED

12669

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Portage			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Box 117			
3. NAME OF DECEASED (Type or print) First Joseph Middle R Last Farrell, Jr.				4. DATE OF DEATH Month December Day 17 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 December 1934		9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Joseph R. Farrell, Sr.				14. MOTHER'S MAIDEN NAME Unknown (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Personnel Records, Fort George G. Meade, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal injuries, two compound fractures, right lower leg DUE TO 5 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Immediate							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident			
20c. TIME OF INJURY Month, Day, Year Hour a m 0445 am Dec 17 1957				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 175, Md	
				20f. (City or town) Jessup Anne Arundel		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased deceased deceased on arrival _____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Army Hospital, Fort George G Meade, Md. 17 Dec 1957							
ACTUAL SIGNATURE John L. Robertson M.D.				24a. REC'D BY REGISTRAR DATE 17 Dec 57			
NAME (Type) JOHN L. ROBERTSON, Capt. MC				24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC			
22a. REMOVAL (Specify) Removal		22b. DATE THEREOF 12-19-1957		22c. NAME OF CEMETERY OR CREMATORY S.O. Bissler Funeral Home		22d. LOCATION (City, town, or county) (State) Kent, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolverton Funeral Home, Inc				24c. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC			

6306 - Belair Road, Baltimore - 6, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUTLER V. R.

DEC 20 1957

RECEIVED

12635 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>46 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>146 MONTICELLO</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ORPHA FOSSETT FELDMeyer</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 28, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>15</u> Min <u>00</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE SANNER</u>				14. MOTHER'S MAIDEN NAME <u>MAE FOSSETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS. L. N. JEFFERSON</u> <u>141 Sp. View Ave., Annapolis, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>110X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PLEURAL EFFUSION</u> (c) <u>METASTATIC CARCINOMA RIGHT BREAST</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 26, 1957</u> to <u>Dec. 16, 1957</u> , that I last saw the deceased alive on <u>Dec. 16, 1957</u> , and that death occurred at <u>6:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>98 Cathedral St., Annapolis, Md.</u> DATE SIGNED <u>12/16/57</u> ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D. PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS M.D.</u> <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-19-57</u>		<u>St. James Cent</u>		<u>Annapolis</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

RECEIVED

12670

CERTIFICATE OF DEATH

12640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AH</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Water Oak Pt.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Water Oak Pt.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. STREET ADDRESS <u>TASADENA RD</u>			
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>C.</u> Last <u>Fleischmann</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1 - 1895</u>	9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Mach.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Chem. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Oscar Fleischmann</u>				14. MOTHER'S MAIDEN NAME <u>Eliz. Schenniger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>1 year</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>57</u> , to <u>12/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>57</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Riviera Beach Md.</u> DATE SIGNED <u>12/14/57</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				<u>RIVIERA BEACH MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Culhy Funeral Homes</u>				ADDRESS <u>130 E. Fort me.</u>		24a. REC'D BY REGISTRAR <u>DATE 17 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>L J Seelby</u>			

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1957



Item 2, Film 223 14 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12641
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE UPPER MALLBORN c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS RT. #14 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) JOSEPH A FLETCHER		4. DATE OF DEATH Month 12 Day 4 Year 1957	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 13, 1911 9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME JAMES FLETCHER	14. MOTHER'S MAIDEN NAME MARY C. PERRY
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT MRS. MARY C. FLETCHER-UPPER MALLBORN Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE TRAUMATIC INJURIES 812 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently struck by auto		
20c. TIME OF INJURY Month, Day, Year Hour 8:30 p.m. 12/4/57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) nr. Davidsonville A.A. Md. (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE Paul F. Guerin M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12-7-57
EXAMINER'S NAME (Type) PAUL F. GUERIN	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12.13.57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery Arlington, Va.	22d. LOCATION (City, town, or county) (State)
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23. FUNERAL DIRECTOR'S SIGNATURE HOLLAND FUNERAL HOME - 1631 PRUID HILL AVE.	24a. REC'D BY REGISTRAR DEC 12 57	24b. REGISTRAR'S SIGNATURE
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

THE HONORABLE

JOSEPH H. FLETCHER

25 4 25

MULTIPLE THROMBOSIS (1905)

BUREAU V. S.

DEC 12 1907

RECEIVED

JOSEPH H. FLETCHER
JAN 10 1908

, 12636

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Anne Arundel General Hospital				d. STREET ADDRESS 30 Monroe Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELMER Middle AUSTIN Last FORD				4. DATE OF DEATH Month DEC. Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 22, 1882	
9. AGE (In years lost birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY State of Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George W. Ford				14. MOTHER'S MAIDEN NAME Priscilla			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-0376		17. INFORMANT Mollie Jane Ford		Address Wife same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 1967 to 23 DEC 1957 , that I last saw the deceased alive on 23 DEC 1957 , and that death occurred at 607 M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck				ADDRESS (Street, city or town, state) 41 Southgate Ave Annapolis, Md.			
PHYSICIAN'S NAME (Type) Edward S. Beck				DATE SIGNED 4/15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemet		22d. LOCATION (City, town, or county) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 3-3-1957	
				24b. REGISTRAR'S SIGNATURE Am. J. Sanchez			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

NOV 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12672 CERTIFICATE OF DEATH

12643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>2yrs. 3mos. 27ds.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1006 N. Central Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Francis</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/80</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>James Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease and Senility</u> DUE TO (c) <u>Gangrene of left foot, Ca. of Cervix?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Senile Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 16</u> , 19 <u>57</u> , to <u>December 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 12</u> , 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u>	
NAME (Type) <u>Lionel McHenry Mapp</u>		DATE SIGNED <u>12/12/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u> </u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hospital disposal</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

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12637 CERTIFICATE OF DEATH

12644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Crisne Annapolis</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>115 Clay St.</u>				-d. STREET ADDRESS <u>115 Clay St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>William</u> Middle <u>William</u> Last				4. DATE OF DEATH <u>12</u> Month <u>6</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>John J. McEwans</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>200-18-6506</u>			
17. INFORMANT <u>Stittie McEwans</u> Address <u>Anna, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>November 14, 1957</u> to <u>Dec 6, 1957</u> , that I last saw the deceased alive on <u>Dec 6, 1957</u> , and that death occurred at <u>1254 PM</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD</u>				DATE SIGNED <u>12/8/57</u>			
ACTUAL SIGNATURE <u>R. B. Richardson</u>				M.D. <u>110-CLAY ST ANNAPOLIS, MD</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beecher</u> ADDRESS <u>108 1/2 St. Anne, Md.</u>				24a. REC'D BY REGISTRAR <u>12/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 10 1904

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12646

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>Few seconds</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McKinsey Road and Route 2</u>		e. STREET ADDRESS <u>McKinsey Road.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry Chester Goudy, Sr.</u>		4. DATE OF DEATH December 9th. 1957	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/10</u>
9. AGE (In years last birthday) <u>47</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney at Law.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Chester Goudy</u>		14. MOTHER'S MAIDEN NAME <u>Mina Klaesius</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes. Navy 1942-45</u>		16. SOCIAL SECURITY NO <u>160-05-9222</u>	
17. INFORMANT <u>Harry Chester Goudy (son)</u>		Address <u>Severna Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest. Brain injury. Laceration of right buttock.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Was driving across route 2 and another vehicle hit his auto-</u>	
20c. TIME OF INJURY Month, Day, Year <u>10.35 a.m. 12/9/57 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 2</u>		20f. (City or town) (County) (State) <u>Severna Park, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/10/57</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balt. 17, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. G. Deakins</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12638

CERTIFICATE OF DEATH

Reg. Dist. No.

12647

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, or If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>				c. LENGTH OF STAY IN 1b <u>Annapolis Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>Ann</u> Middle <u>Gross</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-10-1957</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Harwood Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Albert Gross</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Creek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Albert Gross</u> Address <u>Harwood Md.</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsion, Dehydration, Hypopnea</u>							
475X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute upper respiratory infection</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-16-57</u> , 19 <u>57</u> , to <u>12-17-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-17-57</u> , 19 <u>57</u> , and that death occurred at <u>3:55</u> M, from the causes and on the date stated above.							
DEATH SIGNATURE <u>W.T. Allen</u> M.D. <u>W.L. Caldwell</u> ADDRESS <u>Street, city or town, state</u> DATE SIGNED <u>12-18-57</u>							
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>				<u>Emmanuel Ann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-19-57</u>		<u>Adams Chapel</u>		<u>Bayard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. D. Anna, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>12-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12645

12639

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A. A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shadeside</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>CLARK O. GROSS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 31 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-1-1880</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cryerman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Churston, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gross</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Coates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-18-5110</u>		17. INFORMANT & ADDRESS <u>James Gross - Anna, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
25- (A) IMMEDIATE CAUSE <u>Acute Broncho-Pneumonia</u>							
(B) ANTECEDENT CAUSE(S) DUE TO <u>Encephalomalacia of the</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Left Hemisphere of the</u>							
STATING UNDERLYING CAUSE LAST. (C) <u>Brain</u>						<u>12-14-57</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. M. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/17/1957</u> to <u>12/31/1957</u> , that I last saw the deceased alive on <u>12/31/1957</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>D. R. Richardson</u>		M.D. <u>110-CLAY ST. ANNAPOLIS, MD.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-2-58</u>		NAME OF CEMETERY OR CREMATORY <u>Gross</u>		LOCATION (City, town, or county) (State) <u>Shadeside, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. Thomsen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Giese, Jr. - Anna, Md.</u>		ADDRESS	
DATE <u>1/4/58</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10/1/79

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 223 12-24-57 et

12648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANN</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2 (Earleigh Heights)</u>				d. STREET ADDRESS <u>737 HENNOX ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>RACHEL</u> Middle <u>LEE</u> Last <u>HEMBREE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>19 57</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>17 MAY 19 23</u>											
9. AGE (in years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>											
10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>TENN</u>		12. CITIZEN OF WHAT COUNTRY? 													
13. FATHER'S NAME <u>AARON BAIRD</u>				14. MOTHER'S MAIDEN NAME <u>VINNIA HAILL</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>408-30-7308</u>		17. INFORMANT <u>RED LINDEN RD PC BOX 117 WHITE MARSH BALD CO 21161</u>													
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, right humerus, right femur</u> </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> DUE TO (b) <u>Comm. fracture of right leg 3 inches above ankle</u> </td> </tr> <tr> <td colspan="2"> DUE TO (c) <u>Multiple lacerations scattered over body</u> </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> <u>Sudden</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, right humerus, right femur</u>		INTERVAL BETWEEN ONSET AND DEATH 	DUE TO (b) <u>Comm. fracture of right leg 3 inches above ankle</u>		DUE TO (c) <u>Multiple lacerations scattered over body</u>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<u>Sudden</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, right humerus, right femur</u>		INTERVAL BETWEEN ONSET AND DEATH 															
DUE TO (b) <u>Comm. fracture of right leg 3 inches above ankle</u>																	
DUE TO (c) <u>Multiple lacerations scattered over body</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<u>Sudden</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Was hit by an automobile while walking on the highway</u>													
20c. TIME OF INJURY Hour <u>11:30</u> a. m. <u>12/7</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 2</u>		20f. (City or town) <u>Severna Park, A.A.</u> (County) <u>Md.</u> (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Rustell S. Fisher</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>													
EXAMINER'S NAME (Type) <u>Rustell S. Fisher, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12/9/57</u>													
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>18 DEC 19 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co Md</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. G. B. M. Walters</u>				ADDRESS <u>144 N. S. HICKS ST</u>		24a. REC'D BY REGISTRAR <u>DEC 14</u>											
24b. REGISTRAR'S SIGNATURE <u>R. J. Adkins</u>																	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial or cremation. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director prior to removal.

BUREAU 1. 3

DEC

RECEIVED

12676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Linthicum Heits A A Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Linthicum Heights A A Co Md b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same				c. LENGTH OF STAY IN 1b 7Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 439 Cleveland Rd Linthicum Heights				d. STREET ADDRESS 439 Cleveland Rd A A Co Md			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Walter Ray Hoffman				4. DATE OF DEATH Month Day Year 12-8-1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-16-1911 ?	
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md State Police				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto City Md	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Philiph Hoffman				14. MOTHER'S MAIDEN NAME Rosa Connelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-03-3578		17. INFORMANT Address Audery Hoffman 439 Cleveland Rd Linthicum A A Co Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2, 1957 , to Dec 8, 1957 , that I last saw the deceased alive on Dec 2, 1957 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Milton Linthicum				ADDRESS (Street, city or town, state) DATE SIGNED M.D. 106 W. Maple Rd Linthicum Heights Md. 12/8/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Woodland Cem		22d. LOCATION (City, town, or county) (State) Woodland Balto Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Toulson				ADDRESS 2359 Wash Blvd Balto 30 Md		24a. REC'D BY REGISTRAR DEC 10 57	
				24b. REGISTRAR'S SIGNATURE Alb...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12650

12640

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Annapolis		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Admiral Apts.-219 Hanover St.				d. STREET ADDRESS Admiral Apts.-219 Hanover St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MILDEED HARRISON HOLLIS				4. DATE OF DEATH Month Day Year DECEMBER 30 1957			
5. SEX Female		6. COLOR OR RACE White		7. WIDOWED XXXXXXXXXX WIDOWED		8. DATE OF BIRTH Feb. 28-1891	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 66 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 66 yrs.		IF UNDER 24 HRS. 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk			10b. KIND OF BUSINESS OR INDUSTRY Bulk Ice Cream Plant			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Luther F. Harrison				14. MOTHER'S MAIDEN NAME May Moberly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 214-10-3190		17. INFORMANT Address Edgar H. Hollis- Admiral Apts.219 Hanover St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PHLEBOTROMBOSIS (LEG VEINS) DUE TO (c) CARCINOMA OF COLON PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 MIN. 1 MONTH 1 YEAR							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY , 1957, to DEC. 30 , 1957, that I last saw the deceased alive on DEC. 30 , 1957, and that death occurred at 11:25 M, from the causes and on the date stated above. ACTUAL SIGNATURE John A. Hedeman M.D. 68 Franklin St. 12/30/57. PHYSICIAN'S NAME (Type) Dr. John A. Hedeman Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Mo. French			

RECEIVED
JAN 1
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677 CERTIFICATE OF DEATH

12651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>1103 Division Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Holloway</u> Last <u>Holloway</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Spencer Rawlings</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>7-10 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.H.C.V.D.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>December 3, 19 57</u> , to <u>December 16, 19 57</u> , that I last saw the deceased alive on <u>December 16, 19 57</u> , and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		DATE SIGNED <u>12/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		<u>Crownsville State Hospital, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frances A. Hempley</u>		24. REC'D BY REGISTRAR <u>DEC 20 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>St. M. Joyce</u>		<u>578 W. Biddle St.</u>	

RECEIVED

BUREAU W. S.

1957

2nd Reg. 1/17/57
plate 117
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 12652											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>A. A.</u>							
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>D O A</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>1950 Forest Drive</u>				d. STREET ADDRESS <u>1950 Forest Drive</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Denise</u> First Middle Last				4. DATE OF DEATH <u>12</u> Month <u>26</u> Day <u>1957</u> Year							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-57</u>		9. AGE (In years last birthday) <u>2 mo</u> Months <u>2</u> Days <u>25</u> Hours <u></u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel M. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Bernice D. Wallace</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>Daniel M. Howard</u> Address <u>Anna, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>1240</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Blanket over face - Infant had been coughing early this A.M.</u> DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Checked by mother at 9 A.M. -- blanket over face.</u>							
20c. TIME OF INJURY Month <u>12</u> Day <u>26</u> Year <u>1957</u> <u>9:30</u> a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
				20f. (City or town) <u>A A</u> (County) <u>A A</u> (State) <u>A A</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accidents <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>William Reese, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12/26/57</u>			
EXAMINER'S NAME (Type) <u>William Reese, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-30-57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>			
				22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> (State) <u></u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u>				24a. REC'D BY REG. STRAR <u>12/26/57</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Church</u>			

1193XV5

THOMAS V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12653

Reg. Dist. No.

12642

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Ce A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. S. General Hospt.</u>		d. STREET ADDRESS <u>105 Chester Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Hubbard</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Marina</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yacht Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alonso Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Elinor Ethel Freeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Mary Hubbard</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>148X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>CARCINOMA OF PHARYNX</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>18 MOS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>57</u> , to <u>Dec 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>57</u> , and that death occurred at <u>7:40</u> A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John L. Korman</u> M.D. <u>12/3/57</u>			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-6-57</u>	<u>Cedar Hill Cent</u>	<u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Doyle Sons</u>		ADDRESS <u>Annapolis Md</u>	24a. REC'D BY REGISTRAR DATE <u>12/4/57</u>
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR THE U. S.

DEC 6

NEGATIVE

12678 CERTIFICATE OF DEATH

1265424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie RFD - Point Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie RFD - Point Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 245A - Marley Creek Drive</u>		d. STREET ADDRESS <u>Box 245A RT 2 - Marley Creek Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Ittner</u>		4. DATE OF DEATH Month Day Year <u>December 20 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18, 1887</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR <u>10</u> Months Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GANLEY Plumbers</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ittner</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Beinslow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>11111</u>		16. SOCIAL SECURITY NO. <u>217-01-3795</u>	
17. INFORMANT <u>Mrs. Wilhelmina Ittner</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Diabetes - Mellitus</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1935</u> , to <u>Dec 20, 1957</u> , that I last saw the deceased alive on <u>12/20, 1957</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis J. Glass</u> M.D.		ADDRESS (Street, city or town, state) <u>321 Baltimore Ave</u> DATE SIGNED <u>12/21/57</u>	
PHYSICIAN'S NAME (Type) <u>Louis J. Glass M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 23, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Bunting</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 1957</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Glass</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NO 04 1977

BUREAU V. S.

12643 CERTIFICATE OF DEATH

Reg. Dist. 12655

1. PLACE OF DEATH a. COUNTY <u>D.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Balsenal Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Johnson</u>		4. DATE OF DEATH <u>12-18-1957</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1957</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR <u>7</u> Months	IF UNDER 24 HRS. <u>05</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Osiah Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Margaretta Carr</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Margaretta Carr Brownwood Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>75% Congenital Uterine Obstruction</u> DUE TO <u>resulting in malformation of urinary tract</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-11-57</u> , 19 <u>57</u> , to <u>12-11-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-11-57</u> , 19 <u>57</u> , and that death occurred at <u>9:40</u> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>A.T. Allen</u> M.D. <u>---</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>12-11-57</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>	22d. LOCATION (City, town, or county) (State) <u>Seidmore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Case, Jr. - Anna, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>12/18/57</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

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18-11-10
A
10-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 12-26-57 et

126568

12679

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 yr. 10 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>SVOL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>			d. STREET ADDRESS <u>611 Sharp Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Johnson</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1957</u>		
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 5, 1923</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Jacob Wilkins</u>			14. MOTHER'S MAIDEN NAME <u>Lillian</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Record</u> Address <u>Crownsville State Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cystopyelitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Paresis</u> DUE TO (c) <u>Decubitus Ulcers, Old Lung Abscess?</u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) (State) <u> </u>
21. I certify that I attended the deceased from <u>2/10/50</u> , 19 <u>57</u> , to <u>12/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 26</u> , 19 <u>57</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		M.D. <u>Crownsville State Hospital</u>		DATE SIGNED <u>12/26/57</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>		<u>Crownsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-30-57</u>	22c. NAME OF CEMETERY, OR CREMATORY <u>W.T. Albion</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Hatalstead</u>		ADDRESS <u>918 N. Hill Ave.</u>		24a. REC'D BY REGISTRAR <u>DEC 27</u>	24b. REGISTRAR'S SIGNATURE <u>A. M. Jones</u>

RECEIVED

DEC 11 1957

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, as its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12657

12680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

77

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. <u>County</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>20 y.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harding and Brighthood Avenues</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward W. Kaiss</u> First Middle Last				4. DATE OF DEATH Month <u>December</u> Day <u>7th.</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/90</u>		9. AGE (In years last birthday) <u>67</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U.S. Army Major.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Kaiss</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kohler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Kenneth Daley (Step Son) Cambridge, Mass.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Strangulation by hanging himself with a manilla</u> DUE TO <u>1/2 inch rope tied around his neck and fastened to a floor joist.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>As per 18 above specified.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11.15</u> p.m. <u>12/7/57</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cellar at Home</u>		20f. (City or town) (County) (State) <u>Odenton A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Church Ce.</u>	
23. FURNAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>				24. REC'D BY REGISTRAR <u>12/8/57</u>		25. REGISTRAR'S SIGNATURE <u>Cara Aschupp</u>	

FINCAU V. S.

ALC 10 197

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12658	
12681										CERTIFICATE OF DEATH	
										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland b. COUNTY AA						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. George G Meade Md					c. LENGTH OF STAY IN 1b 1 yr					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. ARMY HOSPITAL					d. STREET ADDRESS 1229 Crawford Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLAUDIE SUE KIMBREL					4. DATE OF DEATH Month Day Year DECEMBER 29 19 57						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Mar 1953		9. AGE (In years last birthday) yrs 4		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Belleville Kansas				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLAUDE R KIMBREL					14. MOTHER'S MAIDEN NAME (MIAIR)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -				16. SOCIAL SECURITY NO. -		17. INFORMANT Address CLAUDE R KIMBREL, 1229 Crawford Drive Glen Burnie Md (Father)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injury, severe, type undetermined DUE TO Unknown Cause Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Complete autopsy revealed by biopsy of adrenal glands as only major fracture, simple, mandible, right										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell down stairs at Officers Club					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ft. G G Meade Md						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1830 p. m. Dec 29 57					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> Officers Club		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ft. G G Meade Md		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 29 Dec 1957 to 29 Dec 1957 , that I last saw the deceased alive on 29 Dec 19 57 , and that death occurred at 1845 PM , from the causes and on the date stated above.											
ACTUAL SIGNATURE Myron Myers					ADDRESS (Street, city or town, state) USAH, FT. G G MEADE MD					DATE SIGNED 29 Dec 57	
PHYSICIAN'S NAME (Type) MYRON MYERS, MD											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 2, 1958 St. Katherine's Ch. Cem.			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Belleville, Kansas			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Singleton					ADDRESS Glen Burnie, Md		24a. REC'D BY REGISTRAR DATE 3 Jan 57		24b. REGISTRAR'S SIGNATURE W. H. Downs, Jr. Capt. M.C.		

FOURTH A. S.

12682 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA MD.</u>		c. LENGTH OF STAY IN 1b <u>30 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bar Harbor Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE A KRATSCH</u>		4. DATE OF DEATH <u>DEC. 4 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 11, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES-USA</u>	
13. FATHER'S NAME <u>CHARLES HENRY KRATSCH</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE VOEEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>WIFE</u>		Address <u>BAR HARBOR RD PASADENA MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CARDIAC DECOMPENSATION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u> <u>3 YRS</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>DEC 4th</u> , 1957, to <u>DEC 4th</u> , 1957, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12⁰⁰</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Arthur Lankford Jr</u>		M.D. <u>MOUNTAIN RD PASADENA, MD.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>12/5/57</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Dealty</u>

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

ned by the hospital or attending physician DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 2 and 3 should be filed with the funeral director. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12660

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Harold St.</u>		d. STREET ADDRESS <u>10 Harold St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Lane</u> Last <u>Lane</u>		4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Bd.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.C. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Lane</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-2013A</u>	
17. INFORMANT <u>Mary Lane - Anna, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162X Bronchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>142</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/6</u> , 1957, to <u>12/25</u> , 1957, that I last saw the deceased alive on <u>12/25</u> , 1957, and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. [Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>37 E. Street, [Address]</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>	22d. LOCATION (City, town, county) (State) <u>Best Gate, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William [Signature]</u> ADDRESS <u>Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>12/26/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

UNITED STATES

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12645 CERTIFICATE OF DEATH

Reg. Dist. No.

12662

1. PLACE OF DEATH a. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>A.A. Co. MO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 HRUCHO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E.</u> Last <u>LARK</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-1897</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+H. R.R. Co. Ret</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES LARK</u>		14. MOTHER'S MAIDEN NAME <u>MARY BYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>J. LAWRENCE MYERS</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>181X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bilateral ureteral obstruction</u> DUE TO <u>Carcinoma of Prostate Gland</u> (c) <u>1 1/2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/4/56</u> , 19 <u>56</u> , to <u>12/29/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/28/57</u> , 19 <u>57</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edwin Davis Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edwin Davis Jr., M.D.</u> <u>98 Cathedral Street, Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	22d. LOCATION (City, town, or county) (State) <u>BROOKLYN MO.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Sons</u> ADDRESS <u>Annapolis Md.</u>		24. REG'D BY REGISTRAR <u>—</u> DATE <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

RECEIVED
JAN 3 1958
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

12683

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>George</i> First <i>Milton</i> Middle <i>Lee</i> Last		4. DATE OF DEATH Month <i>12</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 7, 1895</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Mayo, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>William H. Lee</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Rebecca Bullen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>214-05-1970</i>	
17. INFORMANT <i>George M. Lee, Jr.</i> Address <i>Mayo, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 6, 1957</i> to <i>Dec. 20, 1957</i> , that I last saw the deceased alive on <i>Dec. 20, 1957</i> , and that death occurred at <i>8:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>12/21/57</i>	
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim</i>		<i>Edgewater, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 23, 57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Mayo, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOPPING FUNERAL HOME</i> ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 23 57</i>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT V. S.

RECEIVED
JAN 10 1971

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12684 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>125 Bliss Lane</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Lerch</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3rd.</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/55</u>
9. AGE (In years last birthday) <u>1 y. 11 months.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis John Lerch</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Zimmerman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. F. J. Lerch (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burn of 95% of body</u> <u>716.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>House caught on fire and baby was alone in the attic.</u>	
20c. TIME OF INJURY Month, Day, Year <u>12/30 P.M. 12/3/57</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Glen Burnie, A.A. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		24a. REC'D BY REGISTRAR <u>REC</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Kelly</u>	

DATE SIGNED

12/3/57

RECEIVED
JAN 10 1964

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RECEIVED
JAN 10 1964

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Iter. 7-25-53 12-57 et

12685

CERTIFICATE OF DEATH

12665

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD. b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 3ys, 2mo, 1da		d. STREET ADDRESS 2801 Rayner Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Estelle Middle Lowery Last Lowery		4. DATE OF DEATH Month 12 Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 85 yrs
9. AGE (In years last birthday) 85 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia 15x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Debility DUE TO (c) Multiple Decubitus Ulcers			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis and Senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from October 6, 19 54 , to December 5, 19 57 , that I last saw the deceased alive on December 5, 19 57 , and that death occurred at 4:00 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 12/6/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-10-57	
22c. NAME OF CEMETERY OR CREMATORY Inman Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Lan		24a. REC'D BY REGISTRAR DATE	
ADDRESS 502 Madison		24b. REGISTRAR'S SIGNATURE W. M. Jones	

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12646

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b <u>10</u> - <u>ANNAPOLIS</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>			d. STREET ADDRESS <u>1302 McKinley St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MAE</u> Middle <u>VIRGIE</u> Last <u>LYNESS</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>5</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1885</u>		9. AGE (In years last birthday) <u>72</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>College Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Jacob HILDEBRAND</u>			14. MOTHER'S MAIDEN NAME <u>Mae McDERMOTT</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>515-24-4689</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, LUNG with metastasis</u> <u>165X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 2 Yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>7 Sep</u> , 19 <u>57</u> , to <u>5 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6 Dec 1957</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>U.S.N. Hosp. Anna. Md.</u> PHYSICIAN'S NAME (Type) <u>CDR F. W. MEYER JR.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Troy, Kansas</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2:57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 3 weeks		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Same STATE Same COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 110 Carroll Road						4. DATE OF DEATH Month December Day 31st Year 1957							
3. NAME OF DECEASED (Type or print) Edith A. Marsh		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/82		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired house wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Lucky, Ohio.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Strail						14. MOTHER'S MAIDEN NAME Arndt							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT Rev. Baron M. Marsh (son)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Gustave H. Faubert, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						12/31/57							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Troy Township Cem.				22d. LOCATION (City, town, or county) Wood Co. Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE R. S. Singletary						ADDRESS Glen Burnie, Md.		DATE JAN 13 1958		24b. REGISTRAR'S SIGNATURE R. S. Singletary			

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12667

12687 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		ANNE ARUNDEL MARYLAND		STATE		MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		GLEN BURNIE		CITY (If outside corporate limits, write RURAL and give nearest town)		BALTIMORE	
TOWN				STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		PLAZA MANOR CONV. HOME		1037 SHARP ST			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
MAXWELL MARY				DEC 4		1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	C	MARRIED	7-4-1878	79 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					MARRION Co. GA.		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
BENJAMIN HANDS				MARY HANDS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				PLAZA MANOR CONV. Home - Glen Burnie			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
400.0 IMMEDIATE CAUSE (A)				ARTERIOSCLEROTIC HEART DISEASE			
ANTECEDENT CAUSE(S) DUE TO				DISEASE			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				ARTERIOSCLEROSIS GENERAL			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 55, to Dec 4, 1957, that I last saw the deceased alive on Nov 30, 1957, and that death occurred at 5:00 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
J. J. Leal		102 BIA BLVD. N.E. GLEN BURNIE, Md.		12-4-57			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		12-7-57		Mt. AUBURN Cemetery		Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DEC 9 1957		J. J. Leal		Charles R. Law		802 Md. Ave.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The burial or cremation copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

DEC 9

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12647

CERTIFICATE OF DEATH

12668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Ruxton Road, Woodland Beach</u>	
3. NAME OF DECEASED (Type or print) <u>Jennie</u> First <u>McCarthy</u> Middle <u>McCarthy</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired for 20 years</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles McCarthy</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>La Reine B. Staal</u>		Address <u>Woodland Beach Edgewater, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure and</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Orthostatic cardiovascular disease</u> DUE TO (c) <u>disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 13, 1957</u> , to <u>Dec. 15, 1957</u> , that I last saw the deceased alive on <u>Dec. 15, 1957</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.		ADDRESS (Street, city or town, state) <u>RFD #1 Box 2774 Edgewater, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u>		DATE SIGNED <u>12/15/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lenchy</u>	

3. A REVIEW

03.

12688 CERTIFICATE OF DEATH

12669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a. a.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>214 Zeppelin Ave</u>		d. STREET ADDRESS <u>214 Zeppelin Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>McClure</u> Last <u>McClure</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 March 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR: Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Joseph Layton</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Joseph McClure</u>		Address <u>207 Zeppelin Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Unk.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July 1952</u> to <u>18 Dec 1957</u> , that I last saw the deceased alive on <u>18 Dec 1957</u> , and that death occurred at <u>9:15 P. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>501 Cherry Hill Road</u> DATE SIGNED <u>Renold B. Lightston, Jr.</u>	
ACTUAL SIGNATURE <u>Renold B. Lightston, Jr.</u> M.D.		ADDRESS <u>501 Cherry Hill Road</u>	
PHYSICIAN'S NAME (Type) <u>Renold B. Lightston, Jr. M.D.</u>		ADDRESS <u>Baltimore - 25 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CAL. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BROOKLAND AA. CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELROY O. WILSON</u>		ADDRESS <u>1200 BRANTLEY AVE</u>	
REC'D BY REGISTRAR <u>DEC 26 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Bill Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 21 1961
BUREAU V. S.

12689 CERTIFICATE OF DEATH

Reg. Dist. No.

126708

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1310, Argyle Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>MERCER</u> Last <u>MERCER</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Elvora Bennett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2453 Druid Hill</u>	
17. INFORMANT <u>Mrs Effie Waxmley</u>		Address <u>2453 Druid Hill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SENILE CACHEXIA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>GENERALIZED ARTERIOSCLEROSIS - 7 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MYOCARDIAL DEGENERATION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/3/1948</u> to <u>12/14/1957</u> , that I last saw the deceased alive on <u>12/14/1957</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. J. [Signature]</u>		ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>LUDWIG BENEDIKT</u>		DATE SIGNED <u>CROWNSVILLE, Md - 12/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 18, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Balt. C. T. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. [Signature]</u>		ADDRESS <u>916 Penn. Ave.</u>	
24a. REC'D BY REGISTRAR <u>617105</u>		24b. REGISTRAR'S SIGNATURE <u>A.M. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD V. S.

1957

1/1/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12648

CERTIFICATE OF DEATH

12671

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A. A. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 35 PINKNEY				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
f. STREET ADDRESS 35 PINKNEY				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JANIE-ELLEN-ARMSTRONG-MILNER				4. DATE Month Dec Day 27 Year 1957			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN	
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grader-Picker-Seafood Co.		11. BIRTHPLACE (State or foreign country) ANNE ARUNDEL Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert S. Armstrong				14. MOTHER'S MAIDEN NAME UNKNOWN <i>1st name ROOSE</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-05-0308			
17. INFORMANT WILLIAM D. ARMSTRONG-IRVING				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-27-57 , 19 to 12-29-57 , 19 that I last saw the deceased alive on 12-27-57 , 19 and that death occurred at 8 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. T. Allen M.D.				ADDRESS (Street, city or town, state) Calverton Md DATE SIGNED 12-30-57			
PHYSICIAN'S NAME (Type) A. T. ALLEN				ANNAPOLIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-30-57		22c. NAME OF CEMETERY OR CREMATORY Brewer-Hill		22d. LOCATION (City, town, or county) (State) ANNAPOLIS Md	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks ADDRESS ANNAPOLIS-Md				24a. REC'D BY REGISTRAR DEC 30 1957 24b. REGISTRAR'S SIGNATURE V. D. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

L. A.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12690 CERTIFICATE OF DEATH

12672

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY OR TOWN <u>Marley Park (Glen Burnie P.O.)</u>		CITY OR TOWN <u>Marley Park (Glen Burnie P.O.)</u>		CITY OR TOWN <u>Marley Park (Glen Burnie P.O.)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Wendover Road</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Wendover Road</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Wendover Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>LEE</u> (Last) <u>MOORE</u>				(Month) <u>DECEMBER</u> (Day) <u>4</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 6, 1890</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lee Moore</u>				14. MOTHER'S MAIDEN NAME <u>Harian Dunkin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-05-5896</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth A. Moore</u>		<u>Same as #2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDIAL INFARCT</u>						<u>immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <u> </u>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>Aug 21</u> , 19 <u>49</u> , to <u>12/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bryant L. Jones</u>				ADDRESS (Street, city, town, state) <u>M.D. 4641 Grain Road 5 Glen Burnie</u>		DATE SIGNED <u>12/6/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Dec 4/57</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>R. J. Bellamy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Bellamy</u>		ADDRESS <u>Glen Burnie, Md</u>	
DATE <u>DEC 9 1957</u>							

U. S. ARMY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12673

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Herald Harbor Road				e. STREET ADDRESS Old Herald Harbor Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REBECCA MULLENAX				4. DATE OF DEATH Month December Day 17 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 47 yrs	
9. AGE (In years last birthday) 47		10. FUNDING YEAR Months 12 Days 17 Hours 57		11. BIRTHPLACE (State or foreign country) Crownsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress (Part time)				10b. KIND OF BUSINESS OR INDUSTRY Boatline Rest.		11. BIRTHPLACE (State or foreign country) Crownsville, Md.	
13. FATHER'S NAME Frank Cox				14. MOTHER'S MAIDEN NAME Leona Stein			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 11111		17. INFORMANT Mr. Roland Mullenax, Jr. Address Edgewater, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage into the chest due to gunshot wound of chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 781X DUE TO (c) gunshot wound of chest							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot by son-in-law							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot by son-in-law					
20c. TIME OF INJURY Month, Day, Year Hour 3:30 a.m. 12/17 19 57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Crownsville A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. B. Brighton				ADDRESS Glen Burnie, Md.		24. REC'D BY REGISTRAR DEC 20 1957	
				25. REGISTRAR'S SIGNATURE J. M. Joyce			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Annapolis		c. LENGTH OF STAY IN 1b		1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X/ Mayo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Anne Arundel General Hospital		d. STREET ADDRESS		1		e. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day	
		Mabel				NAYLOR				Dec.		26	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-1-1901		56 yrs.		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY?	
												U.S.	
13. FATHER'S NAME		Ben Brown		14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		218-26-8136		17. INFORMANT		Address		Frank Naylor - Mayo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Acute oedema of the lung		527.2		INTERVAL BETWEEN ONSET AND DEATH		24 hours	
527.2		DUE TO		(b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Chronic pyelonephritis		19. WAS AUTOPSY PERFORMED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour		o. m. p. m.		19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
21. I certify that I attended the deceased from		Dec 26		19 57		to		Dec 26		19 57		that I last saw the deceased alive on	
Dec 26		19 57		and that death occurred at		2:30 PM		from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		Albert R. Anderson		M. D.									
PHYSICIAN'S NAME (Type)													
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)					
Burial		12-31-57		Union Chapel		Davidsonville, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
William Reese - Anna, Md.				DATE		Mr. J. F. Funch							

EDWARD V. S.

EC

RECEIVED

1
FOR STATE
HEALTH DEPT.

12650

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. 12675 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Riva</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hospital</u>		d. STREET ADDRESS <u>Glen Isle</u>	
3. NAME OF DECEASED (Type or print) <u>JENNIE SUE NELSON</u>		4. DATE <u>December 31</u> 19 <u>57</u> DEATH	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 11, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>21</u> yrs. IF UNDER 1 YEAR Months <u>21</u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRY G. NELSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY RYAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>HARRY G. NELSON</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Otitis media, bilateral</u> <u>391.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbington Nat'l.</u>		22d. LOCATION (City, town, or county) (State) <u>Arbington VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Ryan</u>		24a. REC'D BY REGISTRAR <u>AA 3</u>	
24b. REGISTRAR'S SIGNATURE <u>1958</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 5

BUREAU V. S.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12676

Reg. Dist No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Kings</u> <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>1 moth 5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		d. STREET ADDRESS <u>422 42nd Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> <u>O'HARE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Feb 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u>72</u> Days <u>10</u> Hours <u>19</u> Min. <u>57</u>	IF UNDER 24 HRS Months <u>72</u> Days <u>10</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cornelius O'Leary</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Honorka Monohue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Son/Timothy F. O'Hare, Bldg T-2325, Ft Meade, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS <u>PRIMARY</u> CONTINUING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10 December 57</u>			
22a. DATE OF REMOVAL <u>12/11/57</u>		22b. DATE OF REMOVAL <u>12/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Woberton Funeral Home, Inc.</u>				24. REC'D BY REGISTRAR <u>DATE 10 Dec 57</u>		24. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Cap</u>	
<u>6306 - Belair Rd, Baltimore 4, Md</u>							

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DEC 4 1947
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12651

CERTIFICATE OF DEATH

12677

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <i>Maryland</i> COUNTY <i>W.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>135 N. Washington St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Susan</i> Middle <i>Parke</i> Last <i>Parker</i>		4. DATE OF DEATH Month <i>12</i> Day <i>29</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OF RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 17, 1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE (In years lost birthday) yrs. <i>4</i> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>4</i> Days <i>4</i> Hours <i>4</i> Min.
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Bernard Parker</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Ferguson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Bernard Parker - Annapolis, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>None</i> DUE TO (c) <i>None</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>12/29</i> , 19 <i>57</i> , to <i>12/29</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/29</i> , 19 <i>57</i> , and that death occurred at <i>10A</i> :M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert H. Johnson</i>		DATE SIGNED <i>37</i>	
PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>12-30-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 31 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Amj French</i>	

BUREAU V. S.

DEC

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12652

CERTIFICATE OF DEATH

12678

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>WHEAMS CREEK.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>EDGAR</u> Last <u>PEIFER</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 May 1896</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>ELMER PEIFER</u>				14. MOTHER'S MAIDEN NAME <u>ALICE MOSLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u> - - - </u>		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INFARCTION MYOCARDIUM</u> <u>4-2-1-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 December, 1957</u> , to <u>18 December, 1957</u> , that I last saw the deceased alive on <u>18 December, 1957</u> , and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hosp. Annapolis, Md.</u> DATE SIGNED <u>12-19-57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>F. W. MEYER JR. CDR MC USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		22b. DATE THEREOF <u>12-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Easton Hgts. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 22 57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

DEC 1901

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
12653					12679					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <i>A A</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A A General</i>					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A A</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> d. STREET ADDRESS <i>95 Conduit</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>H.</i> Last <i>Pollock</i>					4. DATE OF DEATH Month <i>Dec.</i> Day <i>11</i> Year <i>1957</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-22-1894</i>		9. AGE (In years last b. rthday) <i>63</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Morristown N. J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>N. S. A</i>				
13. FATHER'S NAME <i>John Andrew Young</i>					14. MOTHER'S MAIDEN NAME <i>Elyzabeth H. Hughes</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Harrison Pollock</i>			Address <i>(2)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyperinsulin</i> <i>443X</i> DUE TO <i>Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Sudden</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <i>19</i> a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>E. L. Linhardt</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>E. L. Linhardt</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12-25-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Natal Academy</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>					ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>12/26/57</i>		24b. REGISTRAR'S SIGNATURE	

RECEIVED

DEC 7

BUREAU V. S.

12693

Item 11, William 1-2-50 et

CERTIFICATE OF DEATH

12680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY a. arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Jewell, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		d. STREET ADDRESS 1 none	
3. NAME OF DECEASED (Type or print) LAST POWELL, (N) Middle ANNIE First ANNIE		4. DATE OF DEATH Month DEC. Day 3 Year 1957	
5. SEX F.	6. COLOR OR RACE Cobred	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-1876
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Tracy's, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOS. COATES		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis General (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1955 to Dec 3 1957 , that I last saw the deceased alive on Nov 30 1957 , and that death occurred on 10:54 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Taler M.D.		ADDRESS (Street, city or town, state) 102 Box A Blvd. M.E. Glen Burnie, Md.	
PHYSICIAN'S NAME (Type) JOSEPH TALER		DATE SIGNED 12-4-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/8/57	22c. NAME OF CEMETERY OR CREMATORY Union Chapel	22d. LOCATION (City, town, or county) (State) McKendree
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardaway Salomillo ADDRESS		24a. REC'D BY REGISTRAR 12/10/57	24b. REGISTRAR'S SIGNATURE

BUREAU V. 3

DEC 12 1957

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• 12694 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luthicum</u>				c. LENGTH OF STAY IN 1b <u>6 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>310 Hill Top Rd.</u>				d. STREET ADDRESS <u>310 Hill Top Rd.</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Catherine S. Powell</u>				4. DATE OF DEATH <u>Dec 8 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/13/66</u>	
				9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____	
						11. IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Jacob Sauters</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Moot.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jessie C. Council - (same)</u>	
						Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding from rectum -</u> DUE TO (c) <u>6 hrs -</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Nov 20, 1957</u> to <u>Dec 8, 1957</u> , that I last saw the deceased alive on <u>Dec 8, 1957</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D. <u>Luthicum</u>				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/8/57</u>			
PHYSICIAN'S NAME (Type) _____							
22. BURIAL, CREMATION, REMOVAL (Specify) <u>12-16-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) <u>Luthicum</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>1305 Hartford</u>				24a. REC'D BY REGISTRAR <u>DEC 19 57</u>		24b. REGISTRAR'S SIGNATURE <u>Delmar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EC 12 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12682

Reg. Dist. No.

12654

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hospital</u>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>Susie Mae Queen</u>			4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1957</u>		9. AGE (In years last birthday) <u>6</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Louis Queen</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Queen</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		
16. SOCIAL SECURITY NO. <u></u>			17. INFORMANT <u>Louis Queen</u> <u>Baltimore Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>495</u> DUE TO <u>neumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u></u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-20-57</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	
22d. LOCATION (City, town, or county) (State) <u>Chesterfield Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u>	
				DATE <u>12/26/57</u>	

RECEIVED

DEC 1944

BUREAU OF

12695

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Annarundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millsville	c. LENGTH OF STAY IN 1b 2 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Foxwell Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle S. Last Rogers		4. DATE OF DEATH Month December Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William C. Rogers		14. MOTHER'S MAIDEN NAME Mary Barbine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James A. Rogers		Address Foxwell Road, Millsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cerebro-vascular DUE TO (c) Disease			INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 16, 1955 , to Dec. 21, 1957 , that I last saw the deceased alive on Dec. 20, 1957 , and that death occurred at 9:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin		ADDRESS (Street, city or town, state) Paradise, Maryland	
DATE SIGNED Dec. 21, 1957		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.		24a. REC'D BY REGISTRAR DEC 24 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE L. J. Dealy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC

BUREAU V. 8

RECEIVED

12696

CERTIFICATE OF DEATH

12684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>G.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>G.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
		f. STREET ADDRESS <u>324 Forest Glen Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Wladyslaw Walter Schmidt</u> First Middle Last		4. DATE OF DEATH <u>Dec 26</u> Month Day Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2. 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longsherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Anna Zimmerman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Katherine Schmidt Wife</u>	
17. INFORMANT <u>Katherine Schmidt Wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY FAILURE</u> DUE TO <u>154X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL "CONSUMPTION," ANEMIA (SEC)</u> DUE TO <u>6 months</u>			
(c) <u>CARCINOMA OF THE RECTUM + METAST.</u> DUE TO <u>18 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>no</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>52</u> , to <u>12-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-29</u> , 19 <u>57</u> , and that death occurred at <u>1 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Otto Vogel MD</u> M.D.		ADDRESS (Street, city or town, state) <u>BOX 91-A, PASADENA</u> DATE SIGNED <u>12-27-57</u>	
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 30/57</u>	<u>Green Haven</u>	<u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozaglus</u> ADDRESS <u>1930 Eastern</u>		24a. REC'D BY REGISTRAR <u>DATE 1/30/57</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. B.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12697 CERTIFICATE OF DEATH

Reg. Dist. No. 12685 25

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Walton Ave.		d. STREET ADDRESS 14 Walton Ave.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last SCHUMAN		4. DATE OF DEATH Month Dec. Day 31 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Fruit Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Henry Schuman		14. MOTHER'S MAIDEN NAME Mary M. Rinehart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-18-5559A	
17. INFORMANT Mrs. Marie Catherine Schuman - 14 Walton Av.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Myocardial hyperplasia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) QUESTO		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 9 , 19 57 , to Dec 31 , 19 57 , that I last saw the deceased alive on Dec 31 , 19 57 , and that death occurred at 11:59 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE H. G. Summers M.D. 1101 N. K. St. Baltimore PHYSICIAN'S NAME (Type) H. G. Summers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto., Md.		24a. REC'D BY REGISTRAR DATE 1/2/58	24b. REGISTRAR'S SIGNATURE Eda H. H. H.

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BUREAU V. S.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 26</u> c. LENGTH OF STAY IN 1b <u>5 years</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard Schwemmer</u> First Middle Last 4. DATE OF DEATH Month <u>December</u> Day <u>30th</u> Year <u>19 57</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7 / 30 / 88</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired cook of the U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Schwemmer</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Maner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes for over 25 years.</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mr. Wm. Arthur Schwemmer, Carvel Beach, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/30/57</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		22a. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>	
22b. DATE THEREOF <u>1/2/58</u>		22c. LOCATION (City, town, or county) (State) <u>Catonsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>		24a. REC'D BY REGISTRAR <u>1958</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. McAlister</u>			

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12699

CERTIFICATE OF DEATH

12687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Severna Park Md.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>McLean Circle</u>			
3. NAME OF DECEASED (Type or print) <u>William O. Sekinger</u> First Middle Last				4. DATE OF DEATH <u>20-5-19</u> Month Day Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Sekinger</u>				14. MOTHER'S MAIDEN NAME <u>Winchester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes, Army</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>			
17. INFORMANT <u>Wife Mrs Sekinger</u> Address <u>Severna Park Md.</u>							
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>161X</u> DUE TO <u>Complication of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Lung</u> DUE TO <u>Carcinoma of Lung</u> (c) <u>Carcinoma of Lung</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-5-57</u> , 19 <u>57</u> , to <u>12-20-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 19, 57</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederick R. Halim</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Halim</u>				DATE SIGNED <u>12-20-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Severna Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rusk</u> ADDRESS <u>Box 144 Ford</u>				24. REC'D BY REGISTRAR DATE <u>DEC 24 1957</u>			
				25. REGISTRAR'S SIGNATURE <u>L. J. Seall</u>			

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12700 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Camp Meade Road		d. STREET ADDRESS Camp Meade Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Paul Semanowich		4. DATE OF DEATH Month Day Year December 20, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1892
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Mary Semanowich	
17. INFORMANT Mrs. Mary Semanowich		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung with metastases to parietal pleura & brain. DUE TO (b) 1 year. DUE TO (c) 1 year. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957 to Dec 20 1957 , that I last saw the deceased alive on Dec 17 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE James E. T. Hopkins M.D.		ADDRESS (Street, city or town, state) 205 W. Linvale St #17	
DATE SIGNED Dec 20 1957			
PHYSICIAN'S NAME (Type) JAMES E. T. HOPKINS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23, 1957	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	22d. LOCATION (City, town or county) (State) Ritchie Hgwy, A. A. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE George J. Rone		ADDRESS 4001 Ritchie Hgwy.	24a. REC'D BY REGISTRAR DATE 12/27/57
		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 30 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12689 ✓

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 47, Route #2				4. STREET ADDRESS Box 47, Route #2			
3. NAME OF DECEASED (Type or print) First Middle Last John Francis Sewell				4. DATE OF DEATH Month Day Year December 5 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 45 yrs		9. AGE (In years last birthday) 45 yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harmens, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Sewell				14. MOTHER'S MAIDEN NAME Roberta Burley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-07-7277		17. INFORMANT Address Mrs. Robert Chase (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Stab Wounds of Neck. 982x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause first. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation.					
20c. TIME OF INJURY Month, Day, Year 12:55 a.m. 12/5 19 57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Severn A. A. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial				22b. DATE THEREOF 12-9-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Pate				24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE Clara H. Shipps	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12702 CERTIFICATE OF DEATH

126994
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> *MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jumpers Hole Rd</u>		d. STREET ADDRESS <u>Jumpers Hole Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Frank Shiroky</u>		4. DATE OF DEATH <u>Dec 28 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Shiroky</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Moul</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Daughter Mrs Boulfield Severna Park</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile</u> DUE TO <u>General debility</u> (c) <u>General debility</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19 to <u>1957</u> , 19 that I last saw the deceased alive on <u>26 Dec 1957</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12-28-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u>		ADDRESS <u>1 Glen Burnie</u>	24a. REC'D BY REGISTRAR <u>L. J. Kelly</u>
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JAN 3 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12703

Item 12-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000

CERTIFICATE OF DEATH

12694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 133 N. Division Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Lee Middle Smith Last Smith		4. DATE OF DEATH Month 12 Day 9 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 9 Hours 19 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis of Lungs DUE TO (b) known to us since admission Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown	20f. (City or town) (County) (State) Unknown
21. I certify that I attended the deceased from December 3, 1957 , to December 9, 1957 , that I last saw the deceased alive on December 9, 1957 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 12/10/57	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-14-57	22b. DATE THEREOF 12-14-57	22c. NAME OF CEMETERY OR CREMATORY Marion Man Park	22d. LOCATION (City, town, or county) (State) Phila. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Wanda H. Bullock		ADDRESS 1412 E. Preston St.	
24a. REC'D BY REGISTRAR DATE 12-12-57		24b. REGISTRAR'S SIGNATURE S. M. Joyce	

U. S. AIR FORCE

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12692

12655

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1 PLACE OF DEATH a. COUNTY <u>P. A. Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sandra Ann Sellers</u> First Middle Last		4. DATE OF DEATH <u>Dec 15</u> 19 <u>57</u> Month Day Year	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>2</u> yrs
		11 BIRTHPLACE (State or foreign country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	17. INFORMANT <u>Mary Sellers</u> Address <u>Bristol Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia extensive</u> DUE TO <u>mal nutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>dehydration</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-14</u> , 19 <u>57</u> , to <u>12-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-14</u> , 19 <u>57</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Smiley H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Letham, Md</u> DATE SIGNED <u>12-15-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Masses</u>	22d. LOCATION (City, town, or county) (State) <u>AA Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. P. Hardesty</u> ADDRESS <u>Chesapeake, Md</u>		24a. REC'D BY REGISTRAR <u>Mr. J. French</u> DATE <u>DEC 20 1957</u>	24b. REGISTRAR'S SIGNATURE

BUREAU V. 2.

REC. 1957

RECEIVED

12704

CERTIFICATE OF DEATH

12693

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUND EL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. Meade, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODENTON,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. ARMY HOSPITAL</u>				d. STREET ADDRESS <u>19 GILL STREET</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>J.</u> Last <u>STERNBERG</u> <u>MARY J. STERNBERG</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 NOV 28</u>	9. AGE (In years last birthday) <u>29</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HARRY MOON</u>				14. MOTHER'S MAIDEN NAME <u>WINIFRED LAMAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PERSONNEL RECORDS, FT. MEADE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible pulmonary embolism</u> <u>+16X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart disease</u> DUE TO (c) <u>Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>441X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 Dec</u> , 19 <u>57</u> , to <u>25 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 Dec</u> , 19 <u>57</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Joseph B. Brill</u>				M.D. <u>US ARMY HOSP. FT. GEORGE G. MEADE MD 25 Dec 57</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH B BRILL, Capt, MC,</u>				<u>U.S. Army Hospital Ft. George G. Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Dec. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peterboro, N.Y.</u>		22d. LOCATION (City, town, or county) (State) <u>Peterboro N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Cook, Inc. 1217 St. Paul St. Balto., Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>26 Dec 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>WILBUR H DOWNS JR CAPT MCG</u>			

RECEIVED

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or interment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12694

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo				c. LENGTH OF STAY IN 1b x2 Mayo			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shoreham Beach				d. STREET ADDRESS Shoreham Beach			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES MICHAEL STUMP				4. DATE OF DEATH Month December Day 29 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1957	
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
11. BIRTHPLACE (State or foreign country) Annapolis, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John M. Stump				14. MOTHER'S MAIDEN NAME Dorothy Thorp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Lt John M. Stump USN - Father- same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxiation in aspiration of 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) irritated stomach contents (c) gastritis DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year 310 p. m. 12-29-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Emily H. Wilson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Emily H. Wilson MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/30/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR JAN 2 1958		24b. REGISTRAR'S SIGNATURE 	

2051273XV6

STANDARD R. R.

AN



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olean</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>1005 1/2 West Sullivan Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Karl</u> Middle <u>Whitney</u> Last <u>SWARTS, Jr.</u>		4. DATE OF DEATH Approx. Month <u>Dec.</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 June 1939</u>
9. AGE (In years last birthday) yrs. <u>18</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Karl Whitney SWARTS, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Not available</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>071 30 1224</u>	
17. INFORMANT <u>U. S. Naval Hospital, Annapolis, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>929.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Drowning</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subdural Haemorrhage</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cause Unknown</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Approx. Dec 9 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown</u>		20f. (City or town) (County) (State) <u>Unknown</u>	
21. I certify that I attended the deceased from <u>20 August</u> , 19 <u>57</u> , to <u>3 November</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 November</u> , 19 <u>57</u> , and that death occurred at <u>Unkwn</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John N. Wall</u> M.D.		3 March 1958	
PHYSICIAN'S NAME (Type) <u>John N. Wall</u>		<u>U. S. Naval Station, Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>March 3, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOPPING FUNERAL HOME</u>		22d. LOCATION (City, town, or county) (State) <u>Olean, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 5 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAU V. S.
1958

RECEIVED
JAN 10 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12657 CERTIFICATE OF DEATH

12695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 20 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSP				e. d. STREET ADDRESS MESQUE FARM SPA ROAD			
3. NAME OF DECEASED (Type or print) First JULIAN Middle F Last TAIT				4. DATE OF DEATH Month 12 Day 9 Year 1957			
5. SEX M		6. COLOR OR RACE ORIENTAL		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/00 (?)	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 12 Hours 12 Min 57		11. BIRTHPLACE (State or foreign country) PHILLIPINE ISLANDS		12. CITIZEN OF WHAT COUNTRY? P.I.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER				10b. KIND OF BUSINESS OR INDUSTRY FARM.			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address ADM - ROBT - C - GIFFIN, ANNAPOLIS, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE +45X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEMORRHAGE, RT. MID. CEREBRAL ARTERY DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE							INTERVAL BETWEEN ONSET AND DEATH 24 HRS. U UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/8 , 19 57 , to 12/9 , 19 57 , that I last saw the deceased alive on 12/8 , 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 68 FRANKLIN ST ANNAPOLIS, MD DATE SIGNED 12/9/57							
ACTUAL SIGNATURE Richard N. Peeler M.D.				PHYSICIAN'S NAME (Type) RICHARD N. PEELER ANNAPOLIS, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-10-57		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Address Annnapolis, Md				24a. REC'D BY REGISTRAR DATE 12/10/57		24b. REGISTRAR'S SIGNATURE Frank	

RECEIVED

DEC 12 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12706 CERTIFICATE OF DEATH

Reg. Dist. No.

126967

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT GEO. G. MEADE</u>		c. LENGTH OF STAY IN 1b <u>35 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FORT GEO. G. MEADE ARMY Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>YETTA</u> Middle <u>R.</u> Last <u>TAKS</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>49</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>HARRY ERLICH</u>		14. MOTHER'S MAIDEN NAME <u>Celia Perosofsky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not Known</u>	
17. INFORMANT <u>Phillip Taks</u>		Address <u>2801 Spring Hill Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of the Sigmoid</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> <u>Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>57</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>57</u> , and that death occurred at <u>7:57</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward B. Brown</u> M.D.		DATE SIGNED <u>FT. Meade, Hospital</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mickel Rodesh</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>DEC 18 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. J. Jones & Son</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. A. 10110

107

1011

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 20 Film 243 12707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 12697 24										
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Pasadena RFD</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>James M. Taylor</u> First Middle Last					4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1957</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1957</u>		9. AGE (In years last birthday) yrs. <u>4</u> Months <u>12</u> Days <u>12</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>11111</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>James M. Taylor, Jr.</u>					14. MOTHER'S MAIDEN NAME <u>Ann L. Trimp</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>111114</u>		17. INFORMANT <u>Mrs. Ann L. Taylor</u>		Address <u>Same as #2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration - vomitus.</u> 721.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>										
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>aspirated vomitus</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Pasadena A A</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>E. Linhardt</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. Linhardt</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Dec-11/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Sington</u>					ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Adalby</u>	

BUREAU V. 83

DEC 19 1957

RECEIVED

12658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>U. C.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>U. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>49 Market St.</u>		d. STREET ADDRESS <u>49 Market</u>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>L.</u> Last <u>Trautwein</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James B. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Nichols</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Margaret P. Trautwein</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sansility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>50</u> , to <u>Dec 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-22</u> , 19 <u>57</u> , and that death occurred at <u>6:5</u> M, from the causes and on the date stated above. P ADDRESS (Street, city or town, state) <u>6 SHAW ST ANNAPOLIS MD</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		DATE SIGNED <u>12/23/57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cmt Annapolis Md</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Kyles</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 30 1957

RECEIVED

12708 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Magothy Beach Road</u>		d. STREET ADDRESS <u>Magothy Beach Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>May</u> Last <u>Tull</u>		4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1875</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dorchester Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gabriel H. Cannon</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Ruark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Kennet A. Tull, 902 Andrews Rd., Glen Burnie, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>5 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 5</u> 19 <u>54</u> , to <u>Dec. 10</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 9</u> 19 <u>57</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>RED 8 Box 442 Pasadena, Md.</u> DATE SIGNED <u>Dec 10, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchee Lw., Glen Burnie, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Dellap</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

CERTIFICATE OF DEATH

12700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundle MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		d. STREET ADDRESS 1034 N. Broadway Baltimore, Maryland	
3. NAME OF DECEASED (Type or print) First RUTH Middle B. Last TURPIN		4. DATE OF DEATH Month December Day 11 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1891
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 19 Hours 57 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland; Baltimore	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Wright		14. MOTHER'S MAIDEN NAME Ida Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 4444 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ? yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 30 , 19 57 , to December 11 , 19 57 , that I last saw the deceased alive on December 8 , 19 57 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James M. Pair		ADDRESS (Street, city or town, state) DATE SIGNED 400 N. Carrollton Ave. Balto. 23, Md.	
PHYSICIAN'S NAME (Type) James M. Pair, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		ADDRESS 1000 Brantley Ave.	
24. REC'D BY REGISTRAR 1957		24. REGISTRAR'S SIGNATURE J. D. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EMILY A. S.

• 1957 •

ST. AL. CH.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

CERTIFICATE OF DEATH

12701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Res'dence before admission) o STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. LENGTH OF STAY IN 1b 34 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 202 Third Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park			
				d. STREET ADDRESS 202 Third Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Joseph Wade Sr.				4. DATE OF DEATH Month Day Year December 3 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1892	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Balto. Housing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jesse Wade				14. MOTHER'S MAIDEN NAME Mary Kohrs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1918-1919 215-03-2750		17. INFORMANT Address Mrs. Alma Schoolman Wade Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of L.A. & Metabolic & Cerebral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p m 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Apr 57 , 19 57 , to 3 Dec , 19 57 , that I last saw the deceased alive on 2 Dec 57 , 19 57 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4016 Gov. Ritchie Hwy. Baltimore, Md. DATE SIGNED Dec. 5, 1957							
ACTUAL SIGNATURE Andrew R. Sosnowski M.D.				PHYSICIAN'S NAME (Type) Andrew R. Sosnowski M.D. Baltimore 25, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem. Baltimore, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Force				ADDRESS 4001 Ritchie Hwy.		24a. REC'D BY REGISTRAR DATE 12/9/57	
				24b. REGISTRAR'S SIGNATURE Sha. M. Heston			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

DEC 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12659

CERTIFICATE OF DEATH

12702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>F.F.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 BADGER RD.</u>		d. STREET ADDRESS <u>33 BADGER RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANNE ARMOUR WAINWRIGHT</u>		4. DATE OF DEATH Month Day Year <u>12 3 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS ARMOUR</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA MC NUTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss JEANNE POWERS</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>? (D.O.A.)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from on <u>11-10-57</u> to <u>12-3-57</u> , that I last saw the deceased alive on <u>11-16-57</u> , 19 <u>57</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. <u>63 College Ave 12-4-57</u> PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u> <u>Annapolis, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>BURIAL</u>	<u>12-6-57</u>	<u>St. Ann's</u>	<u>Annapolis MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Galt & Sons</u>		ADDRESS <u>Annapolis, MD</u>	24a. REC'D BY REGISTRAR DATE <u>12/6/57</u>
24b. REGISTRAR'S SIGNATURE <u>William</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 6 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711 CERTIFICATE OF DEATH

12703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN b <u>2 weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Annapolis Rd. Marley Park</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Lea Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James Edward</u> Middle <u>Whay</u> Last <u>Whay</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15th.</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/07</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rainswood, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Lee Whay Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>214-05-3904</u>	
17. INFORMANT <u>Mr. Robert Whay, (brother)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder with metastasis.</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>November 15, 1957</u> , to <u>December 15, 1957</u> , that I last saw the deceased alive on <u>December 10th., 1957</u> , and that death occurred at <u>1.15P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>12/16/57</u>	
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>	22d. LOCATION (City, town, or county) <u>BALTE 25 17d</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Himmey</u> ADDRESS <u>Glen Burnie</u>		24a. REC'D BY REGISTRAR <u>DEC 20 1957</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Aalby</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1937

RECEIVED

1
FOR STATE
HEALTH DEPT.

12712

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) e. STATE <u>aa</u> Same Same COUNTY <u>MD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same Severna Park</u>		d. STREET ADDRESS <u>Same Box 2397</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 239-F</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael James Whitaker</u>				4. DATE OF DEATH Month Day Year <u>December 20th. 19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/57</u>	
9. AGE (In years last birthday) <u>22</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Abington, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Ray Whitaker</u>				14. MOTHER'S MAIDEN NAME <u>Betty Irene Greer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>The Parents. Father R Whitaker</u> (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Noel Craig Cent</u>	
22d. LOCATION (City, town, or county) (State) <u>Abington Va</u>				24a. REC'D BY REGISTRAR DATE <u>12/23/57</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				24b. REGISTRAR'S SIGNATURE <u>U.S. Annapolis Md</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 27 1937

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713 CERTIFICATE OF DEATH

12705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>8 mo. 30 das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		d. STREET ADDRESS <u>1811 W. Franklin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Williams</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Hicks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensated Cardiac Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Mitral Stenosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction, Paranoid Type</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3</u> , 19 <u>57</u> , to <u>December 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Lionel M. McHenry Mapp</u> M.D. <u>Crownsville, Md.</u> <u>12/2/57</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL-CREMAION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Kate R. Williams</u>		24a. REC'D BY REGISTRAR <u>Schroeder St</u>	
24b. REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>		DATE	

19713 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

DEC 6 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12708

12714

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>75 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE State</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> <u>3401-4</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BONIFACE J YOUNG</u>		4. DATE OF DEATH Month Day Year <u>Dec 9 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/79</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James</u>		14. MOTHER'S MAIDEN NAME <u>Susan Doughty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Gravett B. Saunders</u>		Address <u>407 Robert St, Balto</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM AND EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10-12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-24-1957</u> to <u>12-9-1957</u> , that I last saw the deceased alive on <u>12-6-1957</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ludwig Benedikt</u>		ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>LUDWIG BENEDIKT</u>		DATE SIGNED <u>CROWNSVILLE STATE HOSPITAL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-10-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calverton</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan</u>		ADDRESS <u>Balto</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. Joyce</u>	

CERTIFICATE OF DEATH

File No. 10

<p>1. Name of deceased: <i>James J. Kennedy</i></p>	
<p>2. Sex: <i>M</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Dec 2, 1957</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>James J. Kennedy</i></p>	
<p>8. Signature of registrar: <i>[Signature]</i></p>	
<p>9. Date of registration: <i>Dec 3, 1957</i></p>	
<p>10. Place of registration: <i>[Signature]</i></p>	

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DEC 3 1957

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